Streamlining USAID's Gender-Based Violence Initiatives in Health

February 22, 2005, Washington, DC

Meeting Objectives:

1) To gather feedback on assessment report.
2) To identify priorities for USAID Bureau for Global Health.
3) To link assessment to BGH results framework.
4) To obtain input on "Guidance to the Field" document.

Background

UDAID/Washington, conducted a survey in the fall of 2003 to gather information on how USAID is currently working to address gender-based violence in field missions, regional programs, and contracting agencies (CAs) funded by the Bureau for Global Health. The Bureau for Global Health's Office of Population/Reproductive Health (PRH) provided "venture capital" funding to the POLICY Project to assess the gaps and trends in GBV activities supported by USAID and to facilitate a strategic planning process for the Bureau for Global Health (BGH) on this topic.

In this meeting, 21 experts on gender-based violence (GBV) were invited, representing the cooperating agency (CA) community and internal USAID staff. Participants came together to discuss existing and future USAID interventions in gender-based violence within the health sector. Participants reviewed an assessment report of USAID GBV activities as of 2003 written by the POLICY Project, and provided recommendations for the future shape of USAID's policies and actions around gender-based violence as they related to RH/HIV programs.

A second meeting of GBV experts will take place in May 2005. Based on the recommendations of the expert group at the second meeting, POLICY will continue work on programmatic guidelines to be turned over to USAID for internal discussion.

Preliminary discussion*: Feedback/questions on the assessment report*

First, participants felt it necessary to add a definition of gender-based violence to the report. Given that there are several different types of GBV, multiple sets of ethical guidelines for study and work around different behaviors exist. Also, as discussed later, interventions around different types of GBV carry different political opportunities and restrictions. Clarity is needed on which behaviors are covered in this assessment, and which ethical guidelines are most appropriate for use. For example, there was discussion, and no clear conclusion, over whether the WHO ethical guidelines for research focus only on domestic violence. (This discussion on the definition of GBV can be viewed closely along with the discussion of language later in this report.)

Participants expressed concern that, despite broad support, interventions focusing on conflict affected populations were under-represented in the report. Any discussion about

GBV initiatives should consider the possibility that well-intended interventions in this area could cause unanticipated harm; the assessment report should address the possibility of unintended harm.

Participants emphasized that improving the response to victims is a key type of GBV intervention and that the assessment report should distinguish between response and prevention strategies.

Community norms are a critical element in the environment that allows GBV to take place. Participants argued that any intervention which strives to make lasting change must address norms and attitudes at the community level; especially where GBV is viewed by both men and women as normative and permissible. Thus projects cannot target norms and attitudes of providers, men, or women in isolation. That said, in focusing on men or providers, funds are sometimes shifted away from much-needed programs that benefit women. It is also important to address norms and attitudes among youth, where effecting change may be more feasible.

The link between HIV and GBV is an area for careful attention. Participants cited the urgent need to explicate the relationship between GBV and HIV. HIV initiatives may be critical and well-supported openings for integrating GBV interventions.

Participants also discussed issues around monitoring and evaluation of GBV interventions and of GBV in itself. Small and/or short-term projects (many projects highlighted in the assessment report were small and short-term) are difficult to evaluate rigorously: one problem being that funding mechanisms sometimes force initiatives to be evaluated too quickly after completion of projects, curbing the possibility of both achieving and documenting changes that require longer periods of time. A rise in prevalence immediately after a GBV intervention, for example, is often a positive sign since more women are reporting violence.

Participants also were concerned with the efficiency of the current system of gathering and responding to GBV data—with this assessment report already somewhat dated, they questioned the agility with which USAID can respond. An alternative example is the PEPFAR coding system, in which projects can report “violence and coercion” as an activity. This system may be worth investigating as a model for classifying and for monitoring and evaluating GBV activities. If this were in place, however, USAID would need to define indicators for the minimum level of activity projects must employ in order to report that they address GBV.

Participants emphasized the need for a cross-sectoral and multi-donor strategy in researching and intervening in GBV in order to address the problem from multiple strategic perspectives. Interagency funding may be a solution to weaknesses in the administrative procedures of leveraging mission funds for cross-sectoral work. Partnerships with other USAID programs, such as Democracy and Governance, and other US government (USG) departments, especially the Department of Defense, were noted as especially important; particularly in regards to the intersections of GBV and HIV/AIDS.

Participants discussed how centralized the agency's GBV strategy should be. On the one hand, there is the need for centralized strategic leadership and tools and guidance from Washington to help projects in the field more adequately address GBV. On the other hand, a rigid, centralized strategy may stifle participation of community members in the planning process; and may be a hindrance to the creativity that comes out at the grassroots level.

In discussing what a GBV strategy might look like, participants expressed concern over use of the term "gender-based violence", which is sometimes confusing or politically controversial. There also may be difficulties in securing political will to address GBV within HIV interventions. Further, since the US refuses to ratify certain international conventions on women and human rights, most notably CEDAW, other governments and NGOs may approach USAID support with suspicion. Participants also noted the USG's reluctance to use human rights framework to address GBV.

Session A—*Working Groups: What is USAID's comparative advantage in the health sector to address gender-based violence?*

Participants were divided into three small groups and asked to discuss and report on different strengths and constraints to address GBV in the health sector.

1) What are other donors doing?

Participants cited many different donor organizations and projects working in the area of GBV. They highlighted international NGOs, international and local women's NGOs, and other USAID and USG departments. They noted that most donors approach GBV through working groups as part of broader gender mainstreaming policies and that most interventions are ad-hoc and decentralized. Further, they suggested that there is little cross-sectoral or multi-donor integration and that, by and large, funding in this area has been rather limited during the past several years. Programs cited in this discussion were as follows:

- CDC/WHO 8-country study and prevention handbook.
- State Department (and USAID) assessment of refugees and displaced populations.
- RHRC—Foundations; assessments, crisis-oriented services.
- RHRC (USAID funded) includes GBV as one of its interventions mandated in their strategy for refugee populations.
- PAHO.
- World Bank—PRSPs.
- Gates Foundation.
- UNIFEM Trust Fund (Zimbabwe).
- CIDA—XD Canadian-Brazil school programs.
- DFID's new HIV strategy, which includes a GBV strategy, as well as a strategy for emergency contraception.

- Program H/MacArthur.
- SIDA's Inter-American Coalition—violence at large.
- UNFPA—screening, training in health facilities.
- UN agencies hold strategy meetings, but use CEDAW as a "strategy" rather than a formalized global GBV strategy or program.
- Nordic countries--Swedish Sida's funding of the Latin American and Caribbean Consortium on GBV and Health.
- World Council of Churches's anti-domestic violence campaign which included training for religious leaders in DV.
- USAID's Democracy and Governance programs do more work on GBV (but not from a health/reproductive health approach) than do BGH programs.

2) Where can USAID help the most?
Participants cited the following as the most feasible and effective strategies for USAID/BGH to adopt:

Integrate GBV into existing programs. USAID's GBV strategy should be to integrate GBV into existing programs, rather than promoting stand-alone activities. USAID should create policy briefs linking GBV to different sectors; tools and guidance to aid in integrating GBV into existing services and programs; and guidance in evaluating GBV programs.

Focus intervention in health service delivery programs. A strategic entry point for USAID may be to address GBV through health services provision, since service delivery in general is a strength of the agency and as the majority of women have contact with health service, even in developing countries. There are basic gaps in service delivery, in terms of both prevention and response. Providers must have skills to detect GBV as a constraint to other health services in order better care for patients. (A limitation of this view is that it runs the risk of GBV not being viewed as a problem in itself.) In general, providers would probably welcome training in identifying and responding to GBV, in order to improve the quality and effectiveness of health care provision in other areas. Management support is also critical in order for GBV knowledge to enhance health care provision. This support would be a vital element in adopting a 'systems approach' that includes protocols, ongoing provider training, data systems, supplies, and referrals networks.

Adopt a continuum of services framework. The GBV framework should include a "continuum of services" framework. Such a continuum would include key points for health care providers, such as prevention, screening for risk, preventing first occurrence, survivor services and referrals, preventing recurrence, etc. A continuum of services links well with ongoing RH programs.

Address community norms. Attempts to influence providers' attitudes toward GBV may be unsuccessful without also addressing broader normative change in the community. Thus, BCC and mobilization within community support networks are important opportunities for USAID; particularly in terms of influencing norms and

emphasizing prevention of GBV. Religious leaders are one crucial constituency of many community networks to be targeted for training, as victims may first communicate with religious leaders before seeking help elsewhere. Formative research must be done in order to understand overt and covert acceptance and rejection of the norms which allow GBV to take place.

Promote cross-sectoral interventions. Mechanisms such as RFAs may be used to permit multiple funding sources and cross-sectoral interventions. The Global Development Alliance is an example of an opportunity to finance multisectoral activities through one funding source. Cross-sectoral interventions are necessary to address GBV from different perspectives and entry points; an explicit strategy for all USG partners to integrate GBV into HIV projects may aid in cross-sectoral interventions.

Evaluate GBV programs. It is necessary to evaluate existing and future GBV programs. USAID should provide guidance to projects on indicators and other evaluation methods, as well as how to use lessons learned and current data to guide the design and implementation of projects.

3) What are priority areas for USAID/GH?
Participants identified the following priority areas for USAID/BGH in GBV programming:

- USAID's role should be to act as a reference and educational resource for projects in the field by providing "reality-based" tools and training for policy development, program planning, and monitoring and evaluation. Population/reproductive health, safe motherhood, and HIV projects are opportunities for GBV interventions.

- The GBV strategy should become part of an overarching USAID policy statement.

- FGC and trafficking of women should not be included in the GBV framework; these issues need separate, specific strategies and interventions.

- Prevention should be the focus of the GBV strategy: interventions should take place around gender norms at the community level. Services within RH should be a priority given that RH is one of USAID's strengths and that caring for survivors is crucial.

- Helping missions develop cross-sectoral strategies should be a priority; particularly within HIV interventions.

- The strategy must focus on what is known about GBV, especially from promising interventions. Documentation of programs where GBV is not the main focus, but is nonetheless part of the program, is valuable. In the same sense, GBV should be integrated into programs already funded by missions and promising interventions identified in the assessment report and literature review, among others, should be scaled up or used as models for replication. (Scaling up programs is also a challenge, as

this process is difficult, and a specific model may not be successful in different communities/projects.)

- Monitoring and evaluation should be priority areas of focus; particularly in helping to identify indicators for projects that integrate GBV. One of the main findings of the assessment report and the literature review is that the limited number of programs that have been well-evaluated makes it difficult for the agency to make evidence-based decisions.

- Since the assessment report shows that missions are already dedicating significant funds to GBV interventions, it is likely that the political will already exists in the field to implement GBV programs. What is needed, and what should be provided through the IGWG/venture capital effort, is clear guidance for how best to integrate GBV in ways that will make the spending more efficient and effective.

4) What are constraints for USAID/GH?

The group identified the following potential constraints:

- Accepting/adapting model programs and scaling up is a difficult and lengthy process.
- Warning against using sector-wide approaches—it is difficult to leverage funds in SWAPS.
- Vertical funding streams make it difficult to integrate across sectors.
- Short time frames make sustainability challenging or unlikely.
- Projects are often funded through one-year cycles—changing behaviors takes longer than just one year.
- Difficulty in convincing USAID to seriously adopt initiatives that work with men
- Difficulty in convincing USAID to take GBV seriously and to fund GBV programs.
- Need for more active transfer of skills between USAID and local organizations—there is no mechanism to ensure transfer of skills to local orgs and sustainability of programs.
- The Bush Administration's view of violence against women as a moral issue.
- Concern over USAID and USG's comfort level with such terms as "gender" and "gender-based violence." The need for consistency in definition of terms when working with several different regions was emphasized. Participants noted that using the term "violence against women" may turn off some local partners, even though VAW is sometimes accepted in feminist circles. Participants suggested the possibility of focusing on types of violence, or "domestic and sexual violence" rather than using 'GBV'.
- Political context in USA—other countries and feminist groups are sometimes suspicious of USG.
- Keep FGC and trafficking of women separate from GBV—those issues need their own space and approach.

Despite the constraints noted, the following were identified as potential opportunities:

- Violence in conflict settings is of interest to senior management at USAID.
- GBV is a concrete example of "gender" at work..
- Administration's expressed interest in issues related to violence against women.

Session B—*Working Groups: What is a reasonable approach for USAID BGH Guidance to the field on gender-based violence?*

1) What areas are appropriate for large-scale investment of core funding?

- Participants made recommendations for addressing GBV starting within USAID: articulate how GBV affects the strategic objectives (SOs) for Population/Reproductive Health (PRH); explain how GBV affects achievement of intermediate results (IRs); and include specific questions about GBV in requests for applications (RFAs).

- Participants recommended that a gap analysis be performed of GBV work by other donors. They emphasized the importance of using existing data to open a policy dialogue.

- Participants suggested using SOTAs to disseminate best practices on GBV.

- Participants emphasized the need to integrate GBV into existing projects from different sectors. Advocacy and technical assistance to programs working on HIV/AIDS, maternal/neonatal health, and population/reproductive health will help those programs understand that addressing GBV will help them meet their goals.

- Participants recommended that specific attention be paid to improved monitoring and evaluation of GBV interventions; including assessing outcomes of past projects and developing guidelines for future interventions.

2) Which regions/countries should be targeted for centralized programming?

Participants discussed several different options for targeting certain regions and countries for GBV programming, including:

- Focus on one country per region or regional offices to pilot interventions;
- Support 2-4 countries;
- Contine to support established programs/projects working in GBV in order to learn from their experience;
- Focus on categories of countries based on different levels of readiness to deal with GBV issue:
    - Early stage: data to highlight importance of issue, advocacy.
    - Countries which are ready to develop and evaluate interventions.

3) How can GBV be mainstreamed into the work of CAs?

- Within USAID policies and procedures, participants recommended introducing GBV requirements into RFAs and RFPs, project contracts, evaluation criteria, annual work plans and procurement documents.

- Participants expressed the need to develop a framework for action, outlining desired outcomes and ways of reaching them. Key areas to be outlined in the framework for action as discussed were: policy, research, and service delivery.

- Participants also suggested promoting the benefits of GBV integration to the CAs and using core funds to encourage programming. Training would be necessary to enable CAs to integrate GBV into their work. Additionally, participants noted the need for leadership and collaboration among CAs.

- In order to assist in evaluation, participants suggested providing GBV-related process and outcome indicators.

- Participants recommended offering Global Leadership Funds to promote creative, cutting edge GBV work.

4) How can BGH increase evidence-based decision making at the mission level?
- IGWG training and TA to the field.
- Present evidence that fighting GBV improves health/development results and moves it away from being viewed as a human rights issue.
- Provide missions with: TA to implement/develop strategies.
- Encourage missions to support key partnerships in-country.

5) *How can BGH reduce fragmentation among missions while maintaining the benefits of an opportunistic/responsive approach?*

Participants suggested the following as possible approaches for reducing fragmentation and retaining benefits of local interventions:

- Develop a centralized framework;
- Use "RH Response in Conflict Settings" as a model;
- Support thematic and regional networks;
- Develop different planning tools—how to make linkages across sectors in missions so that they end up with an integrated, cohesive strategy;
- Build creativity and harm avoidance (ethical guidelines) into strategy;
- Investigate using a systems approach and identify gaps;
- Encourage dialogue among all CAs working in-country;
- Provide technical assistance.

6) What type of guidance (document) would be most helpful for the USAID community?

Participants offered the following as possibilities for the type of document to produce:
- Technical assistance;

- Key lessons: What to do; what not to do;
- Documents by theme (SOs and IRs)/programming;
- GBV training manual.

Participants offered the following as possibilities for dissemination of the guidance document:

- Distribute to PRH officers in the field;
- Post on IGWG website.

Comments for "Guidance to the Field"

Participants made the following recommendations for the guidance document:

- Among guidelines, draw links between different types of work, e.g. How are BCC efforts linked to policy?
- Track guidelines to BGH structure, i.e. Population/Reproductive Health (PRH), Safe Motherhood (SM), HIV, Child Health (CH), etc.
- Give programmatic examples to achieve the IRs.
- Include upfront a section addressing "what's in it for me?". In other words, use existing data to help folks understand what it means to address GBV in terms of USAID goals. For instance, highlight the link between addressing GBV and reaching agency's strategic objectives (such as reducing pregnancy, maternal mortality, HIV/AIDS infections, etc.) This is easier for some objectives than others, but it would be a good idea to 'spell out' the links.
- Consider preparing / adapting a conceptual framework to address point 1 above.
- Given the potential for unintended negative consequences, include a section on 'What not to do'.
- Whenever possible, mention tools that may be needed and, to the extent that they exist, where they might be found. Again, in some cases, such as for service delivery, a number of tools are available and could be included. However, they may not be available for all technical areas and some research may be needed in order to dig out what does exist.
- The document needs to be short. This seems to be the main challenge, particularly given the request of adding info.

Next Steps

1) Workshop report
2) Follow-up meeting with GBV experts scheduled for May 24, 2005.
3) Continue work on programmatic guidelines.
4) Internal discussions in USAID.

Agenda 2/22/05

9:30-9:45 *Introduction: Purpose of the activity and meeting; presentation of participants*

Elizabeth Neason and Mary Kincaid

9:45-10:45 *What is USAID doing in the area of gender-based violence and health: an assessment of findings, gaps and patterns*

Presenters: Myra Betron, consultant (for Sarah Bott) and Alessandra Guedes, consultant
Facilitator for discussion: Elizabeth Neason

10:45-1:45 *Session A—Working Groups: What is USAID's comparative advantage in the health sector to address gender-based violence?*

- What are other donors doing?
- Where can USAID help the most?
- What are priority areas for USAID/GH?
- What are constraints for USAID/GH?

[12:00-12:45 Working Lunch]

1:45-2:45 *How does it all fit in USAID's Global Health strategic framework: Linking practice to policy*

Presenter: Mary Kincaid
Facilitator for discussion: Elizabeth Neason

2:45-3:00 Coffee Break

3:00-4:15 *Session B—Working Groups: What is a reasonable approach for USAID BGH Guidance to the field on gender-based violence?*

1. Strategic considerations
2. Guidance to the field

Facilitators: Elizabeth Neason, Alessandra Guedes, and Michal Avni

4:15-4:30 Conclusions and Closing Remarks